

# Consumer Guide to Health Insurance Rate Review in Oregon



This booklet explains how the Insurance Division of the Oregon Department of Consumer and Business Services reviews rates for small employer and individual health insurance plans and how consumers can participate.

Rate review is just one way the division regulates the insurance industry. The division also protects consumers by:

- Making sure insurance companies are financially stable and can pay claims.
- Reviewing all types of insurance policies to make sure they are clearly written, contain required benefits, and do not exclude items they must cover.
- Licensing insurance companies and agents (also called producers).
- Providing a help line where consumer advocates are available to answer insurance questions or help resolve complaints against an agent or insurance company.
- Investigating potential violations of insurance law.

**Contact a consumer advocate:**

Phone: 503-947-7984 or

Toll-free: 1-888-877-4894

E-mail: [cp.ins@oregon.gov](mailto:cp.ins@oregon.gov)

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# Health insurance reform in Oregon

On Jan. 1, 2014, many significant pieces of federal health reform took effect. These included:

- Most individuals must have health insurance.
- Everyone is eligible for health insurance, regardless of current or past health status.
- Public programs (Medicaid) expanded and federal tax credits and subsidies helped others afford private health insurance.
- Health plans for individuals and small employers must contain basic (essential) benefits and are easier to compare.
- The Health Insurance Marketplace, at [healthcare.gov](http://healthcare.gov), offers one-stop health insurance shopping and links eligible Oregonians to financial assistance programs for premiums and out-of-pocket costs.

## Health benefit plans: Coverage and cost

### Plans cover essential benefits

All health plans in the individual and small group markets offer comprehensive coverage known as essential health benefits. The exact benefits differ by state and reflect services offered in a typical employer plan. However, all plans must offer essential health benefits in these 10 categories:

- Emergency benefits
- Hospitalizations
- Laboratory services
- Maternity care
- Mental health and substance abuse treatment
- Outpatient, or ambulatory, care
- Pediatric care
- Prescription drugs
- Preventive care
- Rehabilitative and habilitative (helping maintain daily functioning) services

Also, plan labels such as “bronze” and “silver” show consumers that some plans pay more medical costs than others and make it easier to compare plans. For example, all bronze plans pay an estimated 60 percent of the average person’s covered medical costs. Insurers can offer more than one plan in each category.

To make it even easier to compare plans, all insurers in Oregon must offer one bronze plan and one silver plan that are identical across companies. Since the benefits are the same, you can more easily compare price, customer service, and the company’s network of hospitals and doctors.

- **Bronze** – The plan must cover 60 percent of expected costs for the average individual.
- **Silver** – The plan must cover 70 percent of expected costs for the average individual.
- **Gold** – The plan must cover 80 percent of expected costs for the average individual.
- **Platinum** – The plan must cover 90 percent of expected costs for the average individual.



## Making coverage affordable



Subsidies: Low- and moderate-income individuals and families are eligible for financial help to buy coverage through [healthcare.gov](https://www.healthcare.gov). The amount of these tax credits and subsidies, which reduce premiums and out-of-pocket costs for deductibles, co-payments, and co-insurance, depend upon the size of your family and your household income. For example, a family of four making up to \$95,400 (400 percent of the 2014 federal poverty level) may be eligible for tax credits to help lower monthly premiums.



# Health insurance rate review

Historically, only about 10 percent of Oregonians have been covered by plans requiring Insurance Division rate approval. These individuals and small business buyers are considered the most vulnerable consumers because they lack the negotiating power of large groups.

## ✓ The division reviews rates for ...

- Small employers (50 or fewer employees).
- Individuals or families who are self-employed or, for other reasons, don't get insurance through an employer.

## ✗ The division does not review rates for ...

- Large groups (more than 50 employees). These groups negotiate prices with the insurer.
- Self-insured employers, who are subject to federal regulation.
- Government entities such as the Public Employees Benefits Board (PEBB) or the Oregon Education Benefit Board (OEGB).

## What is a rate?

The base price for a health insurance market is known as a base rate. A premium is calculated from the base rate, and is the specific amount a policyholder pays for insurance coverage. Your actual premium will be higher or lower than the base rate, depending on several key factors.

Your family's health, however, is **not** a factor in how much you pay for health insurance. You are part of an insurance pool. The entire pool's medical costs do influence overall rate increases from year to year. Other factors that determine what you pay depend on your insurance choices and demographic information, such as age, where you live, and whether you use tobacco.

The division reviews proposed rates for new health insurance plans, as well as proposed rate changes for existing plans.

## Factors that determine your premium

### Individual plans (for those who do not get job-based coverage).

- Age.
- The benefits you choose.
- The number of family members on the plan.
- Where you live in Oregon.
- Tobacco use.

**Small group (50 or fewer employees).** Insurance companies may use the following factors to calculate premiums:

- The average age of enrolled employees and dependents.
- The benefits the employer selects.
- The number of family members on the plan.
- Geographic location.
- Tobacco use by employees.

**Age:** Premiums for older people cannot be more than three times those charged to younger people in the same geographic area, not considering the impact of tobacco use.

**Family rates:** Family rates in individual health benefit plans are a combined total of the rate each family member receives. However, no more than three children may be included when determining the total rate.

**Tobacco:** People who use tobacco can be charged up to 50 percent more than people who do not. Insurance companies decide how and whether to use tobacco in setting rates.

**Large group (more than 50 employees).** Employers negotiate rates directly with the insurance company; these plans' rates are not subject to state regulation.

When you buy your own insurance as an individual, you pay the premium. When you get coverage through your job, your employer pays the premium or you and your employer share the premium cost.

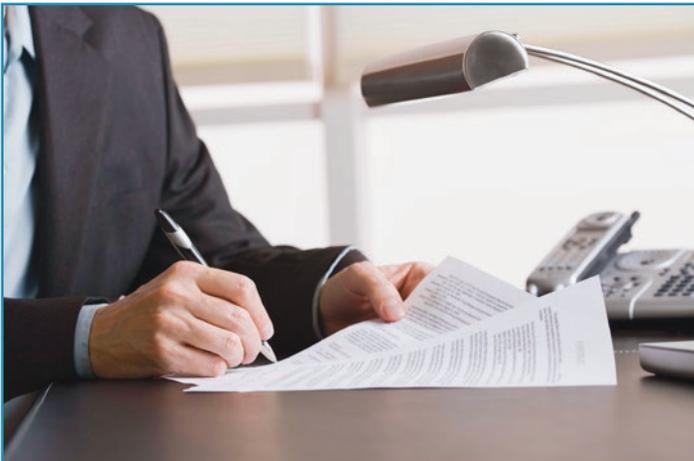
# Rate review process



- 1) An insurance company submits a rate request to the Oregon Insurance Division.
- 2) The division posts all documents on [oregonhealthrates.org](http://oregonhealthrates.org) and sends an email to consumers who signed up for this service to let them know their company filed a request and the date of any public hearing. The public has 30 days to comment. The division posts comments to the website.
- 3) Because the issues are technical, the division uses federal grant money to fund a consumer group to review many rate requests on behalf of consumers.
- 4) The division's actuaries, who specialize in calculating insurance rates and premiums, review the insurance company request.

- 5) Based on all the information received, including public comments, the division evaluates if the rate request is reasonable in relation to the plan's benefits. The division announces preliminary decisions.
- 6) The division holds public hearings. Visit [oregonhealthrates.org](https://oregonhealthrates.org) to see the schedule. If you sign up for email notification, the date of the hearing will also be in an email to you.
- 7) The commissioner makes a final decision. The division posts an explanation of why it approved or disapproved each rate filing at [oregonhealthrates.org](https://oregonhealthrates.org). It sends an email to consumers with a link to the decision.

**Sign up on [oregonhealthrates.org](https://oregonhealthrates.org) to receive an email when your insurance company files a rate request and when the division makes a decision.**



## How to participate

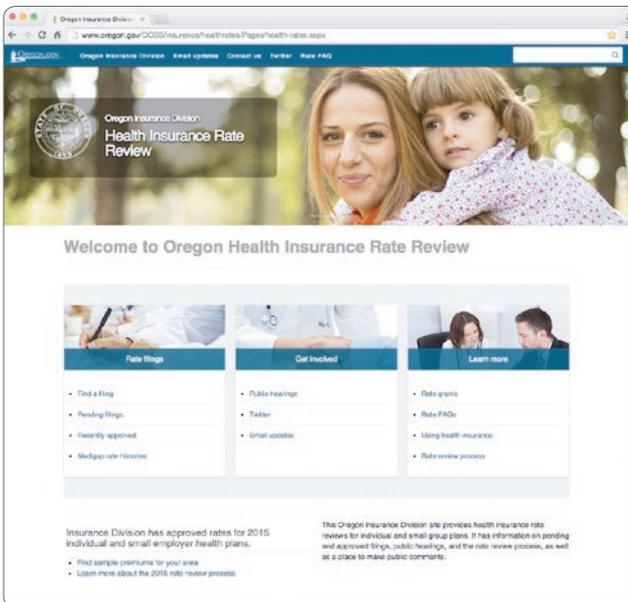
**Comment online.** If you sign up for email notification, we will provide a link to the page where you can make a comment. Also, you can use [oregonhealthrates.org](http://oregonhealthrates.org) to look up a rate request; once you find the rate filing, you will see a “Make a comment” link.

**Attend a public hearing.** Click on the “Public Hearings” button of our rate website ([oregonhealthrates.org](http://oregonhealthrates.org)) to see a schedule and location. The division broadcasts every hearing; the website announces when it is possible to watch the hearing from your computer.

**Make your comment count:** This booklet explains the factors the division must consider in analyzing a rate request.

**Contact the OSPIRG Foundation.** The state uses federal funds to contract with the OSPIRG Foundation to involve consumers in rate review and to help them testify effectively.

Find OSPIRG at <http://ospirgfoundation.org>.



# What your premium covers

## What does a rate cover?

An insurance rate covers:

1. Claims for medical services (hospitals, doctors, pharmacy, lab, and other patient care)
2. Insurer administrative costs
3. Profit (sometimes)

## What drives claims costs?

Many factors influence the actual claims costs and the predicted claims costs. The most important are:

1. Unit cost
2. Utilization

**Unit cost:** This measures medical services inflation. How much more the same services cost one year versus the next is the single largest factor affecting claims costs. Inflation is largely caused by unit price changes in contracts that insurers have with doctors and hospitals as well as increased charges for laboratory services, diagnostic imaging, and other medical services.

**Utilization (use of medical services):** Utilization describes underlying factors that influence the type and quantity of medical services people use. Examples include:

- Aging population
- Increasing number of people in poor health (obesity, for example)
- Changes in how doctors and hospitals diagnose conditions (such as an increase in the use of CT and MRI diagnostic imaging)
- New technologies, new treatment patterns
- New medical equipment to treat conditions

## Where does your premium dollar go?

The **average** breakdown of the premium dollar in Oregon:

- 89 cents – medical claims
- 10 cents – costs of running the company
- 1 cent – profit

These numbers include all of an insurance company's business, even large employers. However, the breakdown varies significantly based on the line of business (small group plans versus individual plans, for example). Every rate request filed with the division, along with the division's decision, includes a projection of how the company will spend your premium dollar if its rate is approved. Visit [oregonhealthrates.org](http://oregonhealthrates.org) to find this information.

**Health insurance premiums reflect the costs of health care. Controlling health care costs is key to stabilizing health insurance rates.**



# Evaluating rate requests

By law, the Insurance Division:

- **Disapproves** rates if “benefits ... are not reasonable in relation to the premium charged.”
- **Approves** rates that are “reasonable and not excessive, inadequate, or unfairly discriminatory.”

Key principles:

- The approved rate and rating factors generate premiums that are fairly priced considering the benefits provided. Reasonable rates are usually adequate to cover the costs of paying for medical services claims and for operating the company. Rates cannot be excessive. That is, insurers should not gouge the public.
- The Insurance Division will not allow rates to be unfairly discriminatory. That means people in similar circumstances should pay similar rates and that rate increases should be shared appropriately between different groups of policyholders.
- The division fosters a marketplace that keeps more people insured and also ensures that insurance companies continue to operate and pay claims. We must balance consumers’ interests in having both the most affordable health care coverage possible and stable and reliable insurance.
- The division cannot control larger economic forces that also affect the marketplace, but it attempts to navigate in the public’s best interests as it reviews rate requests.
- The division seeks to balance the often more conservative assumptions and projections of insurance company actuaries. For example, the division scrutinizes company assumptions about increasing medical claims costs and administrative costs.

**Rates must cover the cost of benefits plus the insurance company’s costs to operate without being overpriced.**

# Key factors

In weighing a rate request, the division considers such factors as an insurance company's:

- ✓ Recent and projected medical care and prescription drug costs, including any benefit changes
- ✓ Past and future loss ratios (how much of every premium dollar goes to pay health care claims)
- ✓ Recent history of rate changes
- ✓ Overall financial strength (profitability, investment income, surplus)
- ✓ Premiums (how they compare to those of competitors)
- ✓ Administrative costs

## Medical services costs

Recent and future costs of medical care and prescription drugs drive insurance rates. Thus, the division closely examines the assumptions behind insurance company estimates about future claims costs, particularly:

- How much will any benefit changes increase or decrease costs?
- Are new contracts with hospitals, doctors, and other providers increasing the unit costs? Why do companies expect policyholders to use more or fewer medical services or a different type of service in the coming year?
- How many policyholders are likely to switch to a higher deductible plan so they can still afford coverage (resulting in less premium to the company)?
- Is there any “margin” or padding in the company's projections?
- To what extent are a company's members aging or are other demographic characteristics changing? How will those changes affect claims?
- What are the average Oregon and national trends in medical claims costs?

## Profit

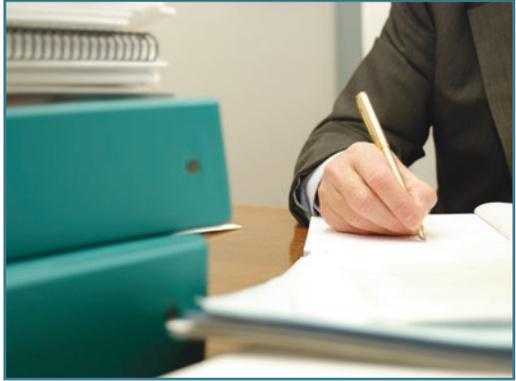
- Oregon's seven largest health insurance companies averaged a less than 2 percent profit in the five years ending in 2013. This profit is generated by their companywide business; it includes everything from profit generated by Medicare and commercial health plans to investment income.
- In some years, a company may be profitable in some lines of business but not others.

## Surplus

- Insurance companies have minimum amounts of capital and surplus so they can pay policyholders' claims. Surplus includes profits accumulated by for-profit and nonprofit companies.
- Companies might use surplus to invest in new technology, protect against adverse conditions such as unexpected claims, or take on additional enrollment and new risk.
- Depending on the circumstances, the division has reduced rate requests to levels that would require companies to use surplus to cover expected losses. However, always using surplus to keep rates artificially low could create a volatile rate situation in the future. If rates do not usually cover expected ongoing increases in health care costs, consumers may face steep rate increases in future years if rates need to suddenly be raised to catch up to the actual medical claims costs.

## Administrative costs

- The division looks at a company's administrative costs as well as its projected growth in administrative costs. Companies must report these costs by type of insurance (individual or small employer health plans, for example). They must break out what they spend on salaries, agent commissions, marketing, advertising, and other expenses.
- Administrative costs are generally higher for individual and small group health insurance compared to large groups. They are typically higher for insurers that write fewer policies or that write several lower-premium, low-benefit policies.
- To help determine if any proposed increase in administrative expenses is reasonable, the division compares the proposed amount to the ***Producer Price Index for Direct Health and Medical Insurance Carriers Industry***, which is published by the federal Bureau of Labor Statistics.
- Insurance companies must pay rebates to individual and small-group policyholders when they fail to spend at least 80 percent of premiums collected on medical care and quality improvement versus administrative costs. They must spend at least 85 percent of premiums on these activities in a state's large group market or pay a rebate.



## **Need help with an insurance question or complaint?**

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